

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

UNITED STATES OF AMERICA *ex rel.*
FRANCESCO LANNI,

Plaintiff,

v.

HCA — THE HEALTHCARE COMPANY,
COLUMBIA MANAGEMENT COMPANIES,
INC., ST. PETERSBURG GENERAL
HOSPITAL, COLUMBIA MEDICAL
CENTER WEST, GREENVIEW REGIONAL
MEDICAL CENTER AND BRANDON
REGIONAL HOSPITAL,

Defendants.

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) Case No. 00-2584 (RCL)
) (Part of 01-MS-50 (RCL))
)

**COMPLAINT OF
THE UNITED STATES**

)
)
) False Claims Act,
) 31 U.S.C. §§ 3729, *et seq.*, and
) Common Law Causes of Action
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)

For its complaint the United States of America alleges as follows:

I. NATURE OF ACTION

1. The United States brings this action to recover treble damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33 and to recover all available damages and other monetary relief under the common law or equitable theories of unjust enrichment, payment under mistake of fact, recoupment of overpayments and common law fraud.

2. These claims are based upon defendants' false claims and false statements made in hospital cost reports submitted to Medicare that contained claims for reimbursement of costs for Procuren, a wound-healing product not reimbursable under Medicare, between January 1, 1993 and at least December 31, 1998.

3. Defendants knowingly concealed, or failed to disclose, or caused others to fail to disclose material information in Medicare cost reports filed by hospitals owned, operated, or managed by HCA – The Healthcare Company, or its predecessor entities (collectively "HCA") in

contravention of the hospitals' certifications that each cost report "is a true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions," as required by federal law and regulation. 42 C.F.R. § 413.24(f)(4)(iv).

4. As a result of defendants' false statements and false or fraudulent cost report submissions, defendants wrongfully obtained payments from Medicare which they knew they were not entitled to receive.

5. The causes of action alleged herein are timely brought on the basis of the filing of relator's complaint in this action and when an official of the United States with responsibility to act under the circumstances knew or reasonably could know facts material to the right of action.

6. HCA and the United States have entered into a series of agreements under which HCA tolled and/or waived the statute of limitations and all related time-based defenses with respect to claims and potential claims of the United States against HCA and all of the HCA affiliated entities named as defendants herein.

II. JURISDICTION

7. The Court has subject matter jurisdiction to entertain this action under 28 U.S.C. §§ 1331 and 1345 and supplemental jurisdiction to entertain the common law and equitable causes of action pursuant to 28 U.S.C. § 1367(a). The Court may exercise personal jurisdiction over the defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the original defendants to this qui tam action resides or transacts business in the Southern District of New York, the transferor Court, and because at least one of the agencies to whom defendant submitted false claims or caused false claims to be submitted maintains their headquarters in this District. Moreover, 28 U.S.C. § 1407 necessarily confers the jurisdiction of the Southern District of New

York over the parties on this Court for this Multidistrict proceeding.

III. VENUE

8. Venue is proper in the Southern District of New York, the transferor Court, under 31 U.S.C. § 3732 and 28 U.S.C. § 1391(b) and (c) because at least one of the original defendants to this qui tam action resides or transacts business in that District. Venue is proper in this District pursuant to 28 U.S.C. § 1407 because this action has been consolidated in this District for pre-trial proceedings.

IV. PARTIES

9. The United States brings this action on behalf of its Department of Health and Human Services ("HHS"), and its agency, the Health Care Financing Administration ("HCFA"), which administers the Medicare Program.

10. Plaintiff and relator Francesco Lanni is a citizen of the United States and a resident of the State of New York. From November 1997 through February 1999, Lanni was employed as Reimbursement Manager at the Wound Care Center at New York Methodist Hospital in Brooklyn, New York.

11. Defendant HCA, formerly Columbia/HCA Healthcare Corporation, is a Delaware corporation that currently operates 189 hospitals and ancillary health care facilities in at least thirty states. At certain times relevant to this complaint, HCA operated over 400 hospitals in at least thirty-five states. HCA was formed on or about February 10, 1994, when Columbia Healthcare Corporation merged with Hospital Corporation of America ("the original HCA"). The merged company changed its name to HCA — The Healthcare Company on May 25, 2000.

12. Columbia Healthcare Corporation ("Columbia") was a Delaware corporation

formed in July 1993, with its principal place of business in Louisville, Kentucky, that owned, operated and managed hospitals in several states.

13. Columbia Hospital Corporation was incorporated on November 19, 1987 as a Texas corporation, and reincorporated on July 26, 1990 as a Nevada corporation, with its principal place of business in Fort Worth, Texas. Columbia Hospital Corporation owned, operated and managed hospitals in several states.

14. Galen Health Care, Inc. (“Galen”) was formed on or about February 12, 1993 as a Delaware corporation with its principal place of business in Louisville, Kentucky as a holding company for the 73 hospitals owned by Humana, Inc.. Humana “spun off” Galen on or about March 1, 1993. Galen is successor in interest to and responsible for the liabilities of Humana for those hospitals. Galen owned and operated hospitals in several states. Galen merged with Columbia in September 1993.

15. Hospital Corporation of America (the original HCA) was a Tennessee corporation with its principal place of business in Nashville, Tennessee. The original HCA owned and operated hospitals in numerous states. The February 1994 Columbia/HCA merger created the largest hospital chain in the United States.

16. HealthTrust, Inc. -- The Hospital Company (“HealthTrust”) was a Delaware corporation with its principal place of business in Nashville, Tennessee. HealthTrust owned and operated hospitals in several states. A subsidiary of defendant Columbia/HCA acquired HealthTrust on April 24, 1995.

17. Epic Healthcare Management Company was a Delaware corporation incorporated on or about September 30, 1988, with its principal place of business in Dallas, Texas, that owned

and operated hospitals in several states.

18. Epic Healthcare Group, Inc. was a Delaware corporation formed on December 14, 1993 which, upon information and belief, became the parent to and responsible for the liabilities of, Epic Healthcare Management Company (collectively “Epic”). HealthTrust acquired Epic by merger on May 5, 1994.

19. As a result of these various mergers and acquisitions, HCA now owns former original HCA, Columbia, Galen, HealthTrust and Epic hospitals, located in several states, and is the successor in interest to, and responsible for the liabilities of, the original HCA, Columbia, Galen, HealthTrust and Epic.

20. Defendant Columbia Management Companies Inc. (“CMC”) is a Delaware corporation formed on December 31, 1996, which has its principal place of business in Nashville, Tennessee. CMC is a subsidiary of defendant HCA. CMC is the successor in interest to certain unincorporated operating groups of Columbia and its predecessors. The unincorporated operating groups included the Midwestern Group, the Eastern Group, and others. CMC, its predecessors, and its subsidiaries were in the business of operating and managing HCA's hospitals and health care facilities, including facilities that operated WCCs.

21. St. Petersburg General Hospital, Columbia Medical Center West, Greenview Regional Medical Center, and Brandon Regional Hospital are the “Hospital Defendants” to this action. The Hospital Defendants are hospitals currently owned by HCA that operate or operated WCCs during a period in which HCA owned the hospital, managed the hospital as general or managing partner, or is the successor in interest to the corporation that owned or operated the hospital during the relevant time period.

22. Attached as Exhibit 1, and incorporated herein by reference, is a chart listing all hospitals whose cost reports are at issue in this action, hereinafter the "HCA Hospitals." The HCA Hospitals are all hospitals that operated WCCs managed by Curative during a period in which HCA owned the hospital, managed the hospital as general or managing partner, or is the successor in interest to the corporation that owned, operated or managed the hospital during the relevant time period. The list of HCA Hospitals includes, therefore, the Hospital Defendants and hospitals which HCA no longer owns. To the extent HCA's liability for the conduct of those hospitals it no longer owns resides in other intermediate corporate entities, those entities will be identified in discovery and named as defendants to this action by amended complaint.

V. THE FALSE CLAIMS ACT

23. The False Claims Act (FCA) provides, in pertinent part that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

* * *

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in

reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729(a) and (b).

VI. THE MEDICARE PROGRAM

24. In 1965, Congress enacted Title XVIII of the Social Security Act ("Medicare" or the "Medicare Program") to pay for the costs of certain healthcare services. Entitlement to Medicare is based on age, disability or affliction with end-stage renal disease. See 42 U.S.C. §§ 426, 426A. Part A of the Medicare Program authorizes payment for institutional care, including hospital, skilled nursing facility and home health care. See 42 U.S.C. §§ 1395c-1395i-4. Most hospitals, including all HCA hospitals whose cost reports are at issue in this action, derive a substantial portion of their revenue from the Medicare Program.

25. During the time period relevant to this complaint, Medicare paid for outpatient hospital services on the basis of the provider's reported costs.

26. HCA and its hospitals operated WCCs as outpatient departments of the hospitals and were, therefore, reimbursed based on their costs.

27. HHS is responsible for the administration and supervision of the Medicare Program. HCFA, an agency of HHS, is directly responsible for the administration of the Medicare Program.

28. To assist in the administration of Medicare Part A, HCFA contracts with "fiscal intermediaries." ("FIs") 42 U.S.C. § 1395h. FIs typically are insurance companies that provide a variety of services, including processing and paying claims and auditing cost reports.

29. During the course of their fiscal year, hospitals submit claims to their assigned FIs for reimbursement for the hospital stays for Medicare beneficiaries that they treat. 42 C.F.R.

§§ 413.1, 413.60, 413.64. Hospitals receive payments on these claims. Within a specified time after the end of the hospital's fiscal year, the hospital must submit its cost report to its FI so that the FI can make year-end adjustments to the amounts paid to the hospital, as needed. 42 C.F.R. § 413.20(b). Cost reports are the final claim that a provider submits to its fiscal intermediary for items and services rendered to Medicare beneficiaries.

30. Cost reports contain specific financial data relating to the hospital including reimbursable costs that the hospital expended to care for Medicare patients. Based on the cost report, Medicare determines whether the hospital is entitled to monies from Medicare in addition to the payments made during the year, or needs to reimburse any overpayments received during the year. 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

31. HCFA requires hospitals, as a prerequisite to payment by Medicare, to annually submit a form HCFA-2552, titled the "Hospital and Hospital Health Care Complex Cost Report".

32. At all times relevant to this complaint, the HCA Hospitals were required to submit cost reports to their FIs.

33. Every hospital cost report contains a "Certification" that must be signed by the chief administrator of the hospital or a responsible designee of the administrator. 42 C.F.R. § 413.24(f)(4).

34. HCFA requires every hospital to certify that to the best of its knowledge and belief the filed cost report is (1) truthful, *i.e.*, that the cost information contained in the report is true and accurate, (2) correct, *i.e.*, that the hospital is entitled to reimbursement for the reported costs in accordance with applicable instructions, and (3) complete, *i.e.*, that the hospital cost report is based upon all of the provider's cost information pertaining to the determination of

reasonable cost.

35. Each cost report prepared and submitted by HCA and the HCA Hospitals included a certification signed by the chief administrator or a responsible designee of the administrator, which states in pertinent part:

to the best of my knowledge and belief, it [the Hospital Cost Report] is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

HCFA Form 2552-81. The cost report form also contained an explicit reminder to the provider that “intentional misrepresentation or falsification of any information contained in this cost report may be punishable by fine and or imprisonment under federal law.”

36. Each cost report prepared and submitted by HCA and the HCA Hospitals after September 30, 1994 contained the following additional sentence:

I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

HCFA Form 2552-94.

37. Each cost report prepared and submitted by HCA and the HCA Hospitals after during 1996 and thereafter contained the following additional notice:

Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

HCFA Form 2552-96.

38. All defendants are and were familiar with the law and regulations governing the Medicare Program, including requirements relating to the completion of cost reports.

39. At all times relevant to this action, the "applicable instructions" referenced in the hospital cost report certification quoted above included the requirements that hospitals seek reimbursement only for allowable costs, and that hospitals exclude unallowable costs, such as Procuren or Procuren related costs, from the costs claimed as allowable.

40. HCFA Form 2552 and HCFA's instructions for completing that cost report form require hospitals to collect and record cost data and patient utilization statistics in a manner designed to determine the true, reasonable, and allowable cost that the hospital incurred to provide care to Medicare beneficiaries during the period covered by the report.

41. Shortly after a hospital submits a cost report, the FI makes a tentative settlement and payment on the cost report as submitted.

42. HCFA conditions the payment of Medicare funds during the year and at year-end on the hospital's certification that the statements contained in the cost report are true. 42 C.F.R. §§ 413.20(e), 413.224(f).

VII. THE DEFENDANTS' SCHEME

43. Beginning in or about 1990, Curative entered into management services contracts with the HCA Hospitals. Under these contracts, the hospital maintained an outpatient Wound Care Center ("WCC") and provided space, equipment and hospital personnel, including clinic physicians and nurses and a medical director, to staff the WCC. Curative in turn provided certain management services to the WCC, and allowed the hospital to use Procuren for a fee.

44. In December 1992, HCFA instructed providers that Procuren was not reimbursable under Medicare because it was not approved by the Food and Drug Administration.

45. Beginning in at least January 1993, Curative informed its hospital clients of

HCFA's decision that Procuren costs should not be included as allowable costs on Medicare cost reports.

46. During the course of a Medicare FI audit of defendant St. Petersburg General Hospital, that began in April 1995, the FI informed senior executives and reimbursement employees of HCA that Procuren and Procuren related services, to wit, blood processing and courier fees paid to Curative, should have been excluded from the allowable costs stated on the hospital's Medicare cost report.

47. On June 9, 1995, HCA's Reimbursement Manager for the Southwest Florida Division wrote a memorandum reporting on the conclusion of the FI's audit, including the disallowance of Procuren and Procuren related services from the Medicare cost report. The memorandum indicated that all HCA Hospitals should exclude Procuren and Procuren related expenses from the costs claimed from Medicare.

48. Despite being informed by Medicare Program instructions, the FI, and internal corporate memoranda identifying Procuren and Procuren related costs as unallowable costs under Medicare, defendant St. Petersburg General Hospital, continued to include such costs in Medicare cost reports submitted for at least fiscal years ending in August 1993, April 1994, and April 1995, as if they were allowable.

49. Throughout the time period relevant to this complaint, HCA and the HCA Hospitals were well-versed in the laws and regulations governing delivery of health care services.

50. St. Petersburg General Hospital (for at least fiscal years ending in August 1993, April 1994, and April 1995), Sam Houston Memorial Hospital (for at least fiscal years ending in

October 1993 and June 1994), Columbia Medical Center West (for at least the fiscal year ending in December 1995), Greenview Regional Medical Center (for at least the fiscal year ending in September 1997), Brandon Regional Hospital (for at least the fiscal year ending in December 1995), and, upon information and belief, certain other HCA Hospitals among those listed on Exhibit 1, but not yet known to the United States, filed cost reports listed on Exhibit 1 that included claims for unallowable Procuren and Procuren related costs after January 1, 1993.

51. Cost reports submitted for the HCA Hospitals were, at all times relevant to this complaint, prepared by, or under the supervision of, employees of the Reimbursement Departments of HCA (including its predecessors) with the assistance of hospital, Division and/or Regional officials.

52. Cost reports submitted for the HCA Hospitals were, at all times relevant to this complaint, signed by hospital officials or employees of HCA's Reimbursement Departments. The person who signed each cost report attested to, among other things, the certifications quoted above.

VIII. FALSE CLAIMS AND FALSE STATEMENTS TO MEDICARE

53. The cost reports submitted for St. Petersburg General Hospital (for at least fiscal years ending in August 1993, April 1994, and April 1995), Sam Houston Memorial Hospital (for at least fiscal years ending in October 1993 and June 1994), Columbia Medical Center West (for at least the fiscal year ending in December 1995), Greenview Regional Medical Center (for at least the fiscal year ending in September 1997), Brandon Regional Hospital (for at least the fiscal year ending in December 1995) and, on information and belief, other of the HCA Hospitals, listed in Exhibit 1, contained false claims for reimbursement and made false statements to

Medicare regarding the allowable nature of the WCC costs for Procuren and Procuren related items and services, costs which defendants knew to be unallowable.

54. Exhibit 1 contains the following information regarding the hospitals and cost report years at issue in this action:

Column	Description
A	Hospital name
B	Hospital City
C	Hospital State
D	Medicare provider number
E	Cost report year-end
F	Hospital's Medicare fiscal intermediary
G	Name of each of the Wound Care Center(s) (WCCs) affiliated with each hospital
H	City where WCC was located
I	State where WCC was located
J	Dates of operation of the WCC

55. The cost reports listed at Exhibit 1 that included claims for Procuren and Procuren related costs contained false certifications that the cost report was “a true, correct and complete statement prepared . . . in accordance with applicable instructions, except as noted.”

56. Those cost reports were false in that HCA and the HCA Hospitals: (a) concealed information relevant to whether they were entitled to payments for hospital services; (b) did not prepare them in accordance with applicable instructions by their failure to declare Procuren costs to be unallowable; and (c) included claims for reimbursement of unallowable Procuren and Procuren related costs as allowable costs.

57. Those cost reports were thus false or fraudulent records, statements and claims.

58. HCA and the Hospital Defendants knowingly filed or caused the filing of those false or fraudulent cost reports to get claims paid.

59. HCA and the Hospital Defendants filed or caused the filing of those cost reports knowing that they contained untruthful or incorrect claims for reimbursement, contrary to their certifications that the filed cost reports were true and correct to the best of their knowledge.

60. These submitted costs reports constitute false claims under the False Claims Act because the defendants knew they included costs that were not reimbursable under the rules and regulations governing the Medicare Program.

IX. DAMAGES

61. The United States was damaged because of the acts of defendants in submitting or causing to be submitted of false claims, statements and records in that it was forced to pay the HCA Hospitals for unallowable Procuren and Procuren related items and services.

FIRST CAUSE OF ACTION

(False Claims Act: Presentation of False Claims)
(31 U.S.C. § 3729(a)(1))
(All Defendants)

62. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 61, as if fully set forth herein.

63. The defendants knowingly presented or caused to be presented false or fraudulent claims for payment or approval to the United States.

64. By virtue of the false or fraudulent claims made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act,

to be determined at trial, plus a civil penalty of \$5,000 to \$10,000 for each false claim.

SECOND CAUSE OF ACTION

(False Claims Act: Making or Using False Record or Statement)
(31 U.S.C. § 3729 (a)(2))
(All Defendants)

65. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 61, as if fully set forth herein.

66. The defendants, and each of them, knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the United States.

67. By virtue of the false records or statements made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of \$5,000 to \$10,000 for each false claim.

THIRD CAUSE OF ACTION

(False Claims Act: Reverse False Claims)
(31 U.S.C. § 3729(a)(7))
(All Defendants)

68. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 61, as if fully set forth herein.

69. The defendants knowingly made, used or caused to be made or used a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the United States.

70. By virtue of the false records or statements made by the defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act,

to be determined at trial, plus a civil penalty of \$5,000 to \$10,000 for each false claim.

FOURTH CAUSE OF ACTION

(Unjust Enrichment)
(All Defendants)

71. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 61, as if fully set forth herein.

72. This is a claim for recovery of monies by which the defendants have been unjustly enriched.

73. By directly or indirectly obtaining government funds to which they were not entitled, the defendants were unjustly enriched, and are liable to account and pay such amounts, or the proceeds or profits therefrom, which are to be determined at trial, to the United States.

FIFTH CAUSE OF ACTION

(Payment By Mistake)
(All Defendants)

74. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 61, as if fully set forth herein.

75. This a claim for the recovery of monies paid by the United States to the defendants by mistake.

76. The United States, acting in reasonable reliance on the accuracy and truthfulness of the information contained in the cost reports submitted by defendants, paid the Hospital Defendants and the other HCA Hospitals identified in paragraph 53 certain sums of money to which they were not entitled, and defendants are thus liable to account and pay such amounts, which are to be determined at trial, to the United States.

SIXTH CAUSE OF ACTION

(Recoupment of Overpayments)
(All Defendants)

77. Plaintiff United States repeats and realleges each allegation in ¶¶ 1 through 61, as if fully set forth herein.

78. This is a claim for common law recoupment, for the recovery of monies unlawfully paid by the United States to the Hospital Defendants and other HCA Hospitals identified in paragraph 53 contrary to statute or regulation.

79. The United States paid the Hospital Defendants and other HCA Hospitals identified in paragraph 53 certain sums of money to which they were not entitled. Defendants are thus liable under the common law of recoupment to account and return such amounts, which are to be determined at trial, to the United States.

SEVENTH CAUSE OF ACTION

(Common Law Fraud)
(All Defendants)

80. Plaintiff repeats and realleges each allegation in ¶¶ 1 through 61, as if fully set forth herein.

81. All defendants made material and false representations in the cost reports they submitted for Medicare reimbursement with knowledge of their falsity or reckless disregard for their truth, with the intention that the government act upon the misrepresentations to its detriment. The government acted in justifiable reliance upon defendants' misrepresentations by settling those cost reports at an inflated amount.

82. Had the true facts been known to plaintiff, all defendants would not have received

payment of the inflated amounts.

83. By reason of its inflated payments, plaintiff has been damaged in an as yet undetermined amount.

PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in favor of it as follows:

1. On the First, Second, and Third, Causes of Action under the False Claims Act, as amended, against all defendants, for the amount of the United States' damages, multiplied as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

2. On the Fourth, Fifth and Sixth Causes of Action, for unjust enrichment, payment by mistake, and common law recoupment against all defendants, for the damages sustained and/or amounts by which defendants were unjustly enriched or by which defendants retained illegally obtained monies, plus interest, costs, and expenses, for an accounting of such monies and such further relief as may be just and proper.

3. On the Seventh Cause of Action, for common law fraud against all defendants, for compensatory and punitive damages, together with costs and interest, and for such further relief

as may be just and proper.

Respectfully submitted,

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